Page 1 - INCIDENT INFORMATION

Completed by Employee/Supervisor

IRI App Incident #: _____

Last revised: Dec 19, 2019

A. IDENTIFICATION INFORMATION:

Last Name: _____ **First Name:** _____ **Employee Contact #:** *(home)* _____

Supervisor Name: _____ **Contact #:** *(work)* _____ *(work)* _____

(cell) _____ *(cell)* _____

MINISTRY: _____ **Division/ Branch/Program:** _____

Work Address: _____ **City/Town:** _____

Employee Occupation: *(Job Title)* _____ **Employee #:** _____

B. INCIDENT INFORMATION:

Date of Incident: *(dd/mm/yy)* | **Time of Incident:** *(am/pm)* | **Specific Location of Incident:**

Reported by: _____ **To:** _____

Date: _____ **Time:** _____

Other parties involved: *(e.g. contractor, public, client, etc.)* _____

Others notified: *(e.g. 911, police/RCMP, OHS Division)* _____

C. TYPE OF INCIDENT: *(Check the applicable box)*

☐ Near Miss (*no injury; no property damage*) ☐ Injury/Illness ☐ Injury/Illness and Property/Equipment Damage

☐ Property/Equipment Damage

D. INCIDENT CATEGORY: *(Check one)*

VIOLENCE
- ☐ Assault
- ☐ Aggression

PHYSICAL EXERTIONS/STRAINS
- ☐ Lifting
- ☐ Overexertion/bodily motion
- ☐ Pushing/Pulling
- ☐ Repetitive Motion

CONTACT WITH OBJECT/EQUIPMENT
- ☐ Caught In/On/Between
- ☐ Struck/Hit

PSYCHO-SOCIAL
- ❑ Work-related Stress
- ❑ Post-incident Distress

EXPOSURE TO HARMFUL SUBSTANCES AND/OR ENVIRONMENTS
- ☐ Animal/Insect
- ☐ Asbestos
- ☐ Biological/Infectious
- ☐ Chemical/Fumes
- ☐ Electric Shock/Electricity/Arc
- ☐ Hot/Cold
- ☐ Noise
- ☐ Light/glare
- ☐ Radiation
- ☐ Water

SLIPS, TRIPS, FALLS
- ☐ On Same level
- ☐ From Elevation
- ☐ On Ice/Slippery Surface

PROPERTY/EQUIPMENT
- ☐ Building
- ☐ Tools/Equipment
- ☐ Fire/Explosion
- ☐ Environment
- ☐ Theft
- ☐ Security

TRANSPORTATION
- ☐ Aviation/Aircraft
- ☐ Licensed Motor Vehicle
  - Vehicle Type: _____
  - CVA Unit #: _____
  - License Plate #: _____
- ☐ Powered Mobile Equipment
  - Unit Type: _____

OTHER *(describe)*

Nature of Injury/Area Affected: *(be specific such as sprained left shoulder; scraped right knee, etc.)*

Treatment Administered:
☐ None ☐ First-aid
☐ Medical Clinic/Emergency Visit

First Aid provided by: _____

Name of medical facility: _____

Lost Time: ☐ No ☐ Yes ☐ Unsure

First scheduled shift missed after incident: *(dd/mm/yyyy)*

❑ Yes, worker submitted a *WCB W1* to WCB.
❑ Yes, worker received a *Stay At or Return to Work Form 111*

E. EMPLOYEE'S DESCRIPTION OF INCIDENT: *(Include details of the activity at the time of the incident. Add attachments if necessary).*

Employee Signature: _____ **Date:** _____ *(dd/mm/yy)*

IMMEDIATE DISTRIBUTION OF PAGE 1 ONLY:
☑ *Central Incident Resource* ☐ *Permanent Head (*as per Ministry direction*)*
☑ *Supervisor/manager* ☐ *Other:*

NOTE: If Dangerous Occurrence/Serious Bodily Injury as per OHS Regulations, immediately contact LRWS OHS Division at 1-800-567-7233 or 1-800-667-5023
Appendix "D" required for all Dangerous Occurrence/Serious Bodily Injury incidents

Page 2 – INCIDENT INVESTIGATION

Completed by Supervisor/Manager

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F. INCIDENT INVESTIGATION: *Add additional attachments as needed*

Check if Applicable: ☐ Serious Bodily Injury/Hospitalization/Fatality (OHS Reg., Section 8) ☐ Dangerous Occurrence (OHS Reg., Section 9)

****Follow Appendix "F"* for guidance*

1. **Employee Name:**
2. **Years/months in position:_____ Related Orientation/Training for task_____**

Investigation Findings: *Consider all factors such as Task, Procedure, Materials, Equipment, Environment, People, Administrative processes that were involved or impact the incident. ADD ATTACHMENTS IF NEEDED.*

Direct Causes: *What event occurred immediately before the incident? What created or had the potential to cause the injury/illness or damage?*

Indirect Causes: *What were the sub-standard acts and/or conditions that contributed to this incident?*

Root Causes: *What were the broader, more systemic underlying causes that were not addressed through the employer's safety management system?*

G. CORRECTIVE ACTION PLAN: (*Actions to correct causes*) *If there are additional actions that are long term, refer to Appendix E*

Corrective Actions to be Taken (to prevent future occurrences)	Responsible Person	Target Date	Status Update	Completed Date
1.				
2.				
3.				

Supervisor Comments:

Signature: *Date:*

Yes/No

_____ Worker submitted *WCB W1* form to WCB?

_____ A *WCB E1* form was submitted to WCB by employer?

_____ A *Stay At or Return to Work Form 111* was received from worker?

_____ Other documentation was completed (describe):

Director/Manager Comments:

☐ Yes, I have spoken with the affected employee(s) to discuss this incident

Signature: *Date:*

Other Comments:

DISTRIBUTE COPIES OF BOTH PAGE 1 & 2:

☑ *Central Incident Resource* ☐ *Employee* ☐ *Supervisor* ☐ *Manager* ☐ *Director* ☐ *OHC Co-chairs (if exist))* ☐ *Other (list):*

Within 7 days as per Ministry Direction

Saskatchewan